



## Original Article

# Evaluation of the quality of life after vertebroplasty to treat compressive osteoporotic fractures<sup>☆,☆☆</sup>



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## ABSTRACT

**Objective:** with increasing life expectancy around the world, fractures due to osteoporosis have become more common and the expenditure for treating them has also increased. The aim here was to evaluate the improvement in pain and quality of life among patients with compressive osteoporotic vertebral fractures undergoing vertebroplasty.

**Methods:** eighteen patients with 27 fractured vertebrae underwent vertebroplasty and were evaluated using the Oswestry 2.0 limitations questionnaire before the operation and 24 h and six months after the operation.

**Results:** there was a 75% improvement in pain and quality of life, going from a mean preoperative Oswestry of 40% to 10% 24 h after the operation and 9% six months after the operation ( $p \leq 0.05$ ).

**Conclusion:** vertebroplasty is effective in managing compressive osteoporotic vertebral fractures, with improvement in pain and quality of life in the immediate postoperative period and over the medium term.

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## Avaliação da qualidade de vida após vertebroplastia em fraturas osteoporóticas compressivas

## RESUMO

**Objetivo:** com o aumento da expectativa de vida no mundo, as fraturas por osteoporose se tornaram mais frequentes e aumentaram também os gastos no tratamento. Avaliar a melhoria na dor e na qualidade de vida de pacientes com fraturas vertebrais osteoporóticas compressivas submetidos a vertebroplastia.

## Palavras-chave:

Vertebroplastia

Fraturas da coluna vertebral

Qualidade de vida

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**Métodos:** foram submetidos à vertebroplastia 18 pacientes com 27 vértebras fraturadas e avaliados pelo questionário de limitações de Oswestry 2.0 de forma pré-operatória, 24 horas e seis meses no pós-operatório.

**Resultados:** melhoria de 75% da dor e na qualidade de vida, com Oswestry médio pré-operatório de 40%, em 24 horas de 10% e após seis meses da cirurgia, de 9%. ( $p \leq 0,05$ ).

**Conclusão:** a vertebroplastia é efetiva no manejo das fraturas vertebrais osteoporóticas por compressão e melhora a dor e a qualidade de vida dos pacientes no pós-operatório imediato e médio prazo.

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## Introduction

Osteoporosis is defined as a disease characterized by low bone mass and deterioration of the bone tissue microarchitecture, which gives rise to increased fragility and consequently greater risk of developing fractures.<sup>1</sup> Dequeker et al.<sup>2</sup> conducted radiological studies on Egyptian mummies from approximately 2000 BC and demonstrated occurrences of vertebral fractures related to osteoporosis.

In the United States, US\$ 20 billion/year is spent on 1.3 million fractures attributed to osteoporosis, of which 500,000 are in the spine.<sup>3</sup> The treatment for compressive osteoporotic vertebral fractures is generally clinical, with analgesia, early walking, vests and anti-reabsorptive medications for osteoporosis, with the aims of avoiding new fractures and diminishing pain and morbidity-mortality.

At the end of the 1990s, Jensen et al.<sup>4</sup> and Deramond et al.<sup>5</sup> indicated vertebroplasty for treating compressive osteoporotic vertebral fractures that had not improved through clinical treatment. This method was originally described by Galibert et al.<sup>6</sup> in 1987, for treating vertebral tumors.

The objective of our study was to evaluate the improvement in pain and quality of life among patients with compressive osteoporotic vertebral fractures who underwent the technique of vertebroplasty following failure of conservative treatment.

## Materials and methods

Eighteen patients with 27 vertebrae affected by compressive osteoporotic vertebral fractures were evaluated between February 2003 and September 2004.

The patients selected for vertebroplasty presented one or more compressive osteoporotic vertebral fractures, with significant pain even after 60 days of clinical treatment consisting of analgesics, non-steroid anti-inflammatory drugs (NSAIDs), opioids, calcitonin, alendronate, calcium, vitamin D and vests and belts for the spine.

Radiography and magnetic resonance imaging (MRI) (with T1/T2/STIR weighted signals) were performed before the operation and radiography and computed tomography (CT) were performed after the operation, on all the patients. MRI showed hypersignal in STIR images, with bone edema in the fractured and painful vertebral body.

All the patients underwent general anesthesia. The routes used for vertebroplasty were posterolateral and

transpedicular, using Jamshid needles and bone cement (polymethylmethacrylate), with 10% barium sulfate for intra-operative viewing by means of fluoroscopy. All the patients were followed up for at least six months after the procedure.

The exclusion criteria were the presence of a compromised medullary canal, infection, coagulation disorders, collapses greater than 90%, fractures of the posterior wall of the vertebra and old fractures that were negative on MRI.

To evaluate the improvement in pain and quality of life, the questionnaire of the Oswestry Disability Index (ODI) (version 2.0) was used during the week preceding the vertebroplasty and 24 h and six months after the procedure.

The statistical test used for comparing the ODI scores was the nonparametric Wilcoxon test, and results were taken to be significant when  $p \leq 0.05$ .

## Results

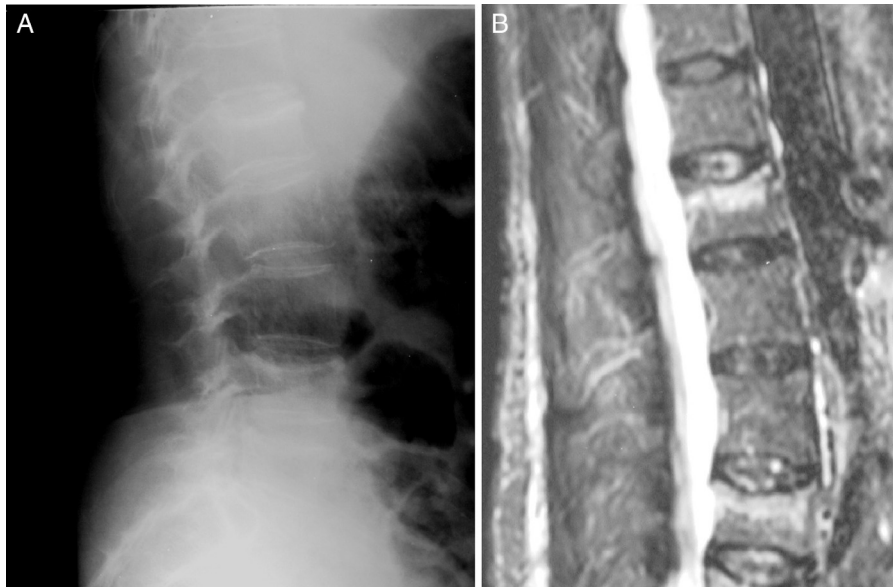
Two men and 16 women were evaluated, with an age range from 50 to 79 years (mean of 64.5), who underwent vertebroplasty due to compressive osteoporotic vertebral fractures (Figs. 1 and 2).

A total of 27 vertebrae were affected: 18 lumbar (L1 to L4) and nine thoracic (T8 to T12). One patient was affected at four levels, one at three levels, four at two levels and 12 at one level. We observed two complications among the cases operated: one case of collapse of an adjacent level, three weeks after the vertebroplasty; and one case of extravasation of cement from L3, with left-side radicular compression. Decompression via a posterior route was performed, with arthrodesis from L2 to L4 using a pedunculated screw (Figs. 3 and 4).

In relation to pain and quality of life, the mean preoperative ODI score was 40% ( $\pm 4$ ) and this changed to 10% ( $\pm 5$ ) within the first 24 h, thus showing a 75% improvement of pain ( $p \leq 0.05$ ). When the ODI score was measured six months later, it was observed that the pain-free condition had been maintained over the medium term, with a mean value of 9% ( $\pm 5$ ) (Fig. 5).

## Discussion

Osteoporosis is a chronic osteometabolic disease with multifactorial causes. It usually has an asymptomatic course, with progressive loss of resistance and bone quality, thereby leading to greater propensity to fractures. Improvement of social conditions, better access to healthcare and better



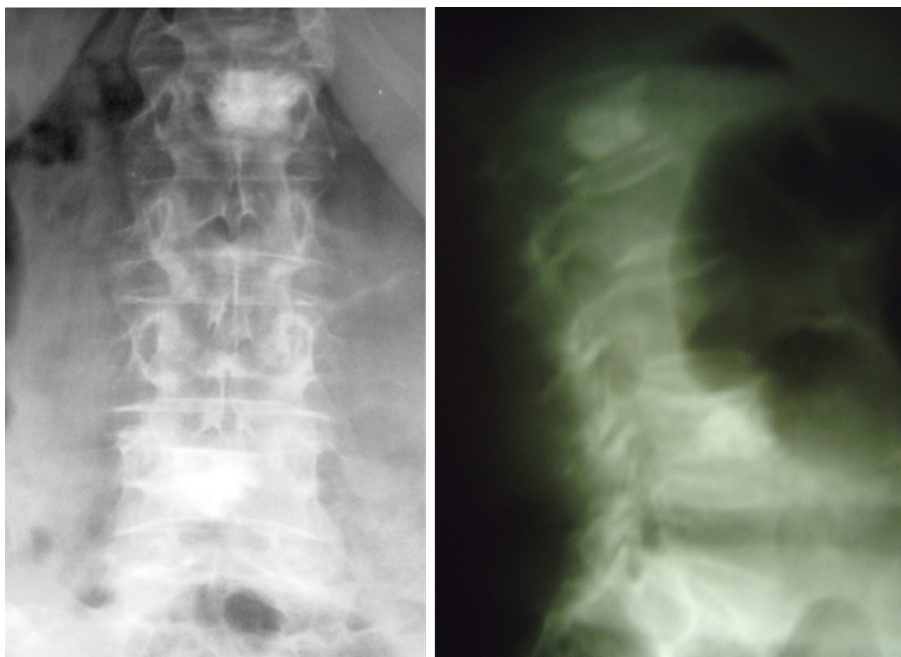
**Fig. 1 – Before the operation: (A) lateral radiograph of the spine showing mild compressive fractures of the superior plateau of the L1 and L4 lumbar vertebrae; (B) sagittal MRI slice showing hypersignal in STIR sequence, in L1 and L4.**

quality of life have provided increased longevity and consequently it has been observed worldwide that the population is aging. Osteoporosis has been described as the “epidemic of the 21st century”<sup>7</sup> and is today considered to be a public health problem, although great advances in its prevention, diagnosis and treatment have been achieved since the 1960s.

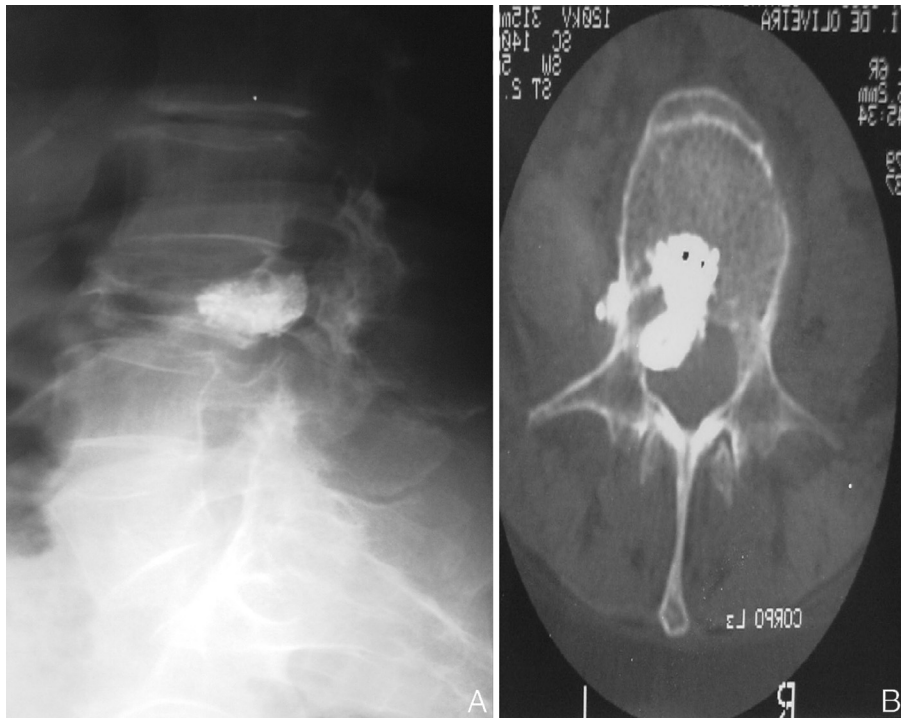
Patients with compressive osteoporotic vertebral fractures often present complaints of back pain/lumbalgia, which may

be acute or chronic. Such complaints are seen among 85% of the patients with a radiological diagnosis of these fractures.<sup>8</sup> The deformities due to the fractures are the most frequent cause of pain. The degree of kyphosis can be correlated with the patients’ quality of life (motor, mental and respiratory function), the mortality rate and the risk of new fractures.<sup>9,10</sup>

This situation leads to sleep disorders, anxiety, depression, diminished social life and increased dependency on



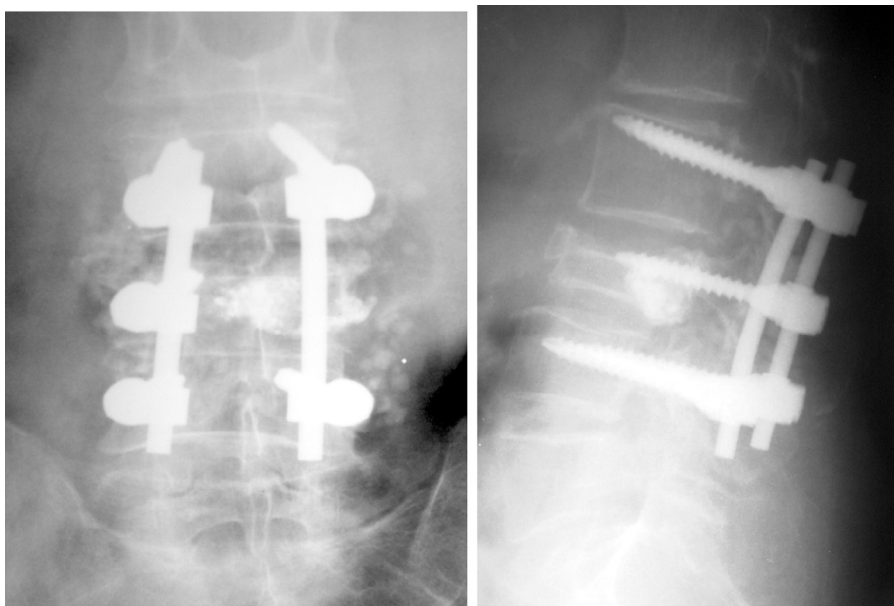
**Fig. 2 – After the operation: anteroposterior and lateral radiographs of the lumbar spine showing bone cement in the vertebral bodies, well positioned in L1 and L4.**



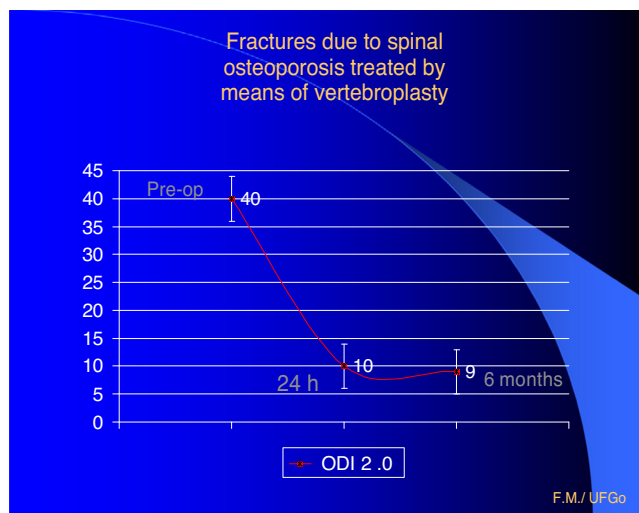
**Fig. 3 – Complication: (A) lateral radiograph of the lumbar spine; (B) axial CT bone slice through lumbar vertebra. Both (A) and (B) show extravasation of the vertebroplasty cement to the medullary canal, with left-side radicular compression.**

other people.<sup>10</sup> The improvement in pain is significant with vertebroplasty.<sup>11,12</sup> Gaitanis et al.<sup>13</sup> observed an improvement in pain on a visual analog scale, from 8.5 before the operation to 2.5 after the operation, and a decrease in the limitations on daily activities assessed through the Oswestry questionnaire from 60% to 28%.

Our results confirm this immediate improvement in pain through vertebroplasty for treating compressive osteoporotic vertebral fractures, with a decrease in the Oswestry index from 40% to 10%. Moreover, this is a safe procedure when performed using the correct technique, with lower morbidity than in decompression surgery and arthrodesis.



**Fig. 4 – Anteroposterior and lateral radiographs of the lumbar spine showing decompression in L3 and posterolateral arthrodesis using pedunculated screws from L2 to L4, as a consequence of extravasation of the cement following vertebroplasty.**



**Fig. 5 – Decrease of the ODI score from 40% to 10%, 24 h after vertebroplasty, and its maintenance at 9%, six months after the procedure.**

## Conclusion

Vertebroplasty is effective in managing compressive osteoporotic vertebral fractures. It improves patients' pain and quality of life immediately after the operation and this is maintained over the medium term.

## Conflicts of interest

The authors declare no conflicts of interest.

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